Eff. Date: __/__/____
Eff. Pay Period: _____
Employee ID#: _____

City of Boulder | Life Event Benefits Change Form

Please return completed/signed form to Human Resources
HRSubmitForms@bouldercolorado.gov
or 3065 Center Green Drive

EMPLOYEE INFORMATION

Printed Name (First, Middle Initial, Last)_____ Social Security Number_____

MID-YEAR LIFE EVENT ACTIONS

The City of Boulder plans allow for changes outside of annual open enrollment only when an event creates a special open enrollment period. The change must be allowable under the Internal Revenue Code and correspond to and be consistent with the special life event. (Speak with Human Resources to know what corresponds to your event.) You are required to provide proof of the event that creates the special period allowing changes. You must submit this form and proof of the event no later than 31 days after the event. More details on life mid-year plan changes can be found in the benefits guide.

Provide Date of Event: _____		*Attach relationship and/or event documentation*
ENROLL/CHANGE due to event	CANCEL due to event	Comments:
☐ Birth/Adoption ☐ Marriage ☐ Domestic Partnership/Civil Union ☐ Court Order ☐ Involuntary Loss of Coverage ☐ Return from Leave ☐ Change in Employment Status ☐ Change in Dependent Care Cost ☐ Other (explain in comments box)	☐ Unpaid Leave of Absence ☐ Divorce/Legal Separation ☐ Termination of Partnership/Union ☐ Death of a Dependent ☐ Child over age 26 ☐ Family Member ☐ Other (explain in comments box)	

Name Change

Current Name (First, Middle Initial, Last)_____

New Name (First, Middle Initial, Last)_____

Bring new social security card to Human Resources front desk for confirmation and copying.

	CIGNA HEALTHCARE	DELTA DENTAL	VISION SERVICE PLAN
Plan:	☐ $500 Deductible Open Access Plan ☐ $1,000 Deductible Open Access Plan ☐ $1,500 Deductible and HSA-Eligible Open ☐ Waive Medical Coverage	☐ Delta Premier ☐ Delta Preferred ☐ Waive Dental Coverage	☐ Enroll-Base ☐ Enroll-Buy Up ☐ Waive Vision Coverage
Tier:	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family

Use* A to Add *and* R to Remove *the following Dependents to/from my coverage:

Add or Remove?	Dependent's Name (First, MI, Last)	Relationship	Dependent's Social Security #	Gender	Date of Birth (MM/DD/YYYY)	Disabled? (Y/N)	A/R to/from Medical? (Y/N)	A/R to/from Dental? (Y/N)	A/R to/from Vision? (Y/N)

Note: Allowable relationships include spouse, domestic partner, civil union partner, birth child, adopted child, child for whom you have legal guardianship, disabled child over the age of 26, partner's child for whom you are responsible, step child, any other person you have been granted legal guardianship for through the courts.

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Health Care Flexible Spending Account (HC FSA)		
Available to all benefits eligible employees. Eligible expenses must be incurred between January 1 and March 15 of the following year. Any monies remaining in the account as of March 31 are forfeited.		
☐ Enroll/Change ☐ Waive	*What amount would you like to contribute to this account via payroll deduction for the remainder of the year?*	Annual Election Amount *(minimum $120, maximum $2,500)* *$*_____
Health Savings Account (HSA)		
Available to all employees who elect the $1,500 Deductible plan. Eligible expenses must be incurred after the creation of the account. Any monies remaining in the account at the end of the year are retained by the employee. Employees age 55 or older may contribute an additional $1,000.		
☐ Enroll (Changes are in Section A) ☐ Waive	*If you are choosing to enroll, what amount would you like to contribute to this account via payroll deduction each pay period?*	Per Pay Period Election Amount *$*_____
Dependent Care Flexible Spending Account (DC FSA)		
Available to all benefits eligible employees. Eligible expenses must be incurred between January 1 and December 31. Any monies remaining in the account as of March 31 are forfeited.		
☐ Enroll/Change ☐ Waive	*If you are choosing to enroll, what amount would you like to contribute to this account via payroll deduction for the remainder of the year?*	Annual Election Amount *(minimum $120, maximum $5,000)* *$*_____

Additional Life and Accidental Death & Dismemberment Coverage		
☐ Enroll/Increase Amount ☐ Cancel ☐ Update Beneficiaries *Review the plan certificate for details on coverage amounts at various ages and for benefits for dismemberment.	Additional Life purchased through payroll deduction: Mid-Year requests to increase coverage require a supplemental form for medical underwriting approval. You may elect spouse coverage up to 100% of the amount requested for the employee. Election Amount for Coverage on Employee *(minimum $10,000, maximum $300,000)* *$*_____ Election Amount for Coverage on Spouse *(minimum $10,000, maximum $300,000)* *$*_____	Additional Life purchased through payroll deduction: You may elect up to $10,000 on your children. The entire amount is guaranteed issue. The cost is the same, no matter the number of children you have. Election Amount for Coverage on Child(ren) *(You may elect $2,500, $5,000, $7,500, or $10,000)* *$*_____
Beneficiary Designation: The employee is automatically the beneficiary on Spouse and Child coverage amounts. Below please designate your primary and contingent beneficiaries.		
<u>Primary</u>		
Name:	Relationship:	% of benefit:
Name:	Relationship:	% of benefit:
<u>Contingent</u> (Only if all primary beneficiaries pre-decease you)		
Name:	Relationship:	% of benefit:
Name:	Relationship:	% of benefit:

Note: A beneficiary can be a person, an estate, a trust or an organization.

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Supplemental Retirement Savings		
457 plan administered by ICMA	**401(k)** plan administered by PERA	**HSA** administered by Optum Health Bank
☐ Enroll, requires a supplemental form ☐ Cancel contributions ☐ Increase or Decrease contributions New percentage of payroll _____% New dollar amount per pay check $_____	☐ Enroll, requires a supplemental form ☐ Cancel Contributions ☐ Increase or Decrease contributions New percentage of payroll _____% New dollar amount per pay check $_____	☐ Enroll, requires an online application ☐ Cancel Contributions ☐ Increase or Decrease contributions New percentage of payroll _____% New dollar amount per pay check $_____ ☐ Apply the change above for: ☐ The remainder of the payroll year ☐ A set number of pay checks # of checks _____

Signature for Insurance Carriers

I confirm that the information I have provided on this form is complete and accurate.

I understand that the benefit plans that I have selected provide reimbursement for certain costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me or expenses which I have incurred may not be covered by my benefit plan.

I understand that the terms of the contract between the insurance carrier and my employer may not allow late enrollment for me and my dependents.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention products or services that might be valuable to me and otherwise as permitted by law. I understand that my information on benefits may be combined in aggregate at the carrier level with other member's information so that it is no longer individually identifiable and can be used for commercial and other purposes.

I authorize payroll deduction of any applicable employee premiums for these benefits.

Date: _____ Signature: _____

Employees working in standard positions but working less than 20 hours per week are not eligible to participate in any of the above insurance plans.

If you are interested in AFLAC coverage, please contact our representative directly to discuss enrollment or changes.